SESSION PRINT: 07/16/04

PAGE: 1

DISCHARGE STATUS: NONE

ROBERTSON , RICKY

708320Q 30001068644

Adm Date: 07/16/04

Attending: 06947 ANTWI MD, STEPHEN

Svc/Team: ERT

Room/Bed: ER

ER 015 ET

Resident:

Ht:

Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

Intern: Diagnosis:

kg Sex: F Isol: N

CM TRANSPORT:

TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:

NKA-UNVERIFIED

DEP DESCRIPTION

ORDER #

21

LAB (ER) LITHIUM LEVEL VENOUS ONCE STAT

START DT/TM: 07/16/04 01:10

19

(ER) LACTIC ACID PLASMA VENOUS ONCE STAT

PHYSICIAN ORDER SHEET -

START DT/TM: 07/16/04 01:10

20

(ER) HEPATIC FUNCTION PANEL VENOUS ONCE STAT

PANEL TESTS ORDERED:

ALB, ALK PHOS, ALT, AST BILI BU/BC, TOT BILI, TOT PROT

START DT/TM: 07/16/04 01:11

----- Ordered By: 07674 MOVVA MBBS, SUNIL

191313 @ 07/16/04 01:09 33 -----

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01:12 07/16/04 FROM H102,0ESES0FA

PHYSICIAN ORDER SHEET -

SESSION PRINT: 07/16/04

PAGE: 2

DISCHARGE STATUS:

Attend	ing: 06947 ANTWI MD, STEPHEN Pager:	• •	R 015 ET
Reside		Age: 37 yrs 10 mos 25 days Birth Date: 08	/21/1966
Intern Diagno		Wt: kg Ht; cm BSA: Sex: F Isol: N TRANSPORT: TDC #:	001172218
Diagno		TOTAL TENTE IN TRANSPORT.	
	RGIES/CONTRAINDICATIONS: UNVERIFIED		
DEP	DESCRIPTION		ORDER
		PHYSICIAN SHEET CONTINUED	
	(ER) ACETAMINOPHEN LEVEL VENOUS ONC	STAT	1:
	START DT/TM: 07/16/04 00:34		
	(ER) AMMONIA PLASMA VENOUS ONCE STAT	·	1.
	START DT/TM: 07/16/04 00:34		
	(ER) DRUG PANEL 3 SERUM VENOUS ONCE	STAT	1.
	START DT/TM: 07/16/04 00:34		
	(ER) KETONE SERUM VENOUS ONCE STAT		1
	START DT/TM: 07/16/04 00:34	• •	
	(ER) SALICYLATE VENOUS ONCE STAT		17
	START DT/TM: 07/16/04 00:34		
		the organ comme	
	(ER) BLOOD GAS-ARTERIAL ACUTE ARTERI	AL ONCE STAT	18

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00:34 07/16/04 FROM D119,OESES0FA

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PHYSICIAN ORDER SHEET -

SESSION PRINT: 07/16/04

PAGE: 1

DISCHARGE STATUS:

OBE	RTSON ,RICKY	708320Q	30001068644 Adm Da	ate: 07/16/04
Attend:	ing: 06947 ANTWI MD, STEPHEN	Pager:	·	n/Bed: ER ER 015 ET
Reside			Age: 37 yrs 10 mos 25 days 1	• •
Intern			Wt: kg Ht: cm	BSA:
Diagno	sis:		Sex: F Isol: N TRANSPORT:	TDC #: 001172218
	RGIES/CONTRAINDICATIONS: UNVERIFIED			
DEP	DESCRIPTION			ORDER
LÆB	(ER) TSH (THYROID STIMU START DT/TM: 07/16/04 0		ONCE	
	(ER) T4 (THYROXINE, TOT START DT/TM: 07/16/04 0	•	CE	sent.
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	(ER) BASIC METABOLIC PA PANEL TESTS ORDERED:	NEL VENOUS ON	CE STAT	Sent 13
		CA, GLU, CREAT, I	BUN	1
	START DT/TM: 07/16/04 0	0:34		
	(ER) CBC - WITH DIFFERE	NTIAL VENOUS	NCE STAT	
	START DT/TM: 07/16/04 0	0:34		
	(ER) MAGNESIUM SERUM VE	NOUS ONCE STAT		1
	START DT/TM: 07/16/04 0	0:34		/
	(ER) PHOSPHORUS, SERUM	VENOUS ONCE ST	rat /	
	START DT/TM: 07/16/04 0	0:34		
	(ER) ER URINE DRUG SCRE	EN 4 CLEAN CA	TCH/VOIDED ONCE STAT	
	START DT/TM: 07/16/04 0			
	(ER) PT (PROTHROMBIN TI	ME) VENOUS ON	E STAT	
	START DT/TM: 07/16/04 0	0:34		
\	(ER) APTT VENOUS ONCE S	TAT	/	
	START DT/TM: 07/16/04 0		/	
	(ER) CKMB WITH TOTAL CK	VENOUS ONCE S	TAT	1
	START DT/TM: 07/16/04 0		/	
	(ER) TROPONIN I QUANTITA	ATIVE VENOUS C	NCE STAT	1:
1	START DT/TM: 07/16/04 00	0:34		•
	(ER) MAGNESIUM SERUM VEI	NOUS ONCE STAT		1:
	START DT/TM: 07/16/04 06	0:34		
			PHYSICIAN SHEET	CONTINUED

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00:34 07/16/04 FROM D119, OESESOFA

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	•	Copy of OIG case to Litig	Original - Medi ation Support on 06.26.2013 by scm. Pink - Phy	cal Record partment

PHYSICIAN ORDER SHEET -

SESSION PRINT: 07/16/04

PAGE: 1

DISCHARGE STATUS: NONE

ROBERTSON , RICKY

Pager:

708320Q 30001068644 Adm Date: 07/16/04

cm

Attending: 05464 BEARY MD, WILLIAM M

Svc/Team: MPU MICU

Room/Bed: J4A J4A 05 IA

Resident: 07674 MOVVA MBBS, SUNIL

Wt: 104. kg Ht:

Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

Intern: Diagnosis:

Sex: M Isol: N TRANSPORT:

TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:

NKA-UNVERIFIED

DEP DESCRIPTION

ORDER #

CON CONSULT: FOOD AND NUTRITION - ASAP SEE COMMENTS

23

COMMENTS: POSITIVE SCREEN CONSULT: NUTRITIONAL RISK.OD PATIENT *********************************** FROM: Y73C KHEDERLARIAN RN , BERTHA

START DT/TM: 07/16/04 05:20

----- Ordered By: 05464 BEARY MD, WILLIAM M

@ 07/16/04 05:19 31 -----

Confidential: Medical Record Copy - Place in Patient's Chart

05:20 07/16/04 FROM MS01,0ESES0FA

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						Medical Record Form 5 Iniversity of Texas Me Galveston,	dical Bra		spital

PHYSICIAN ORDER SHEET -

SESSION PRINT: 07/16/04

PAGE: 1

DISCHARGE STATUS: NONE

ROBERTSON , RICKY

Pager:

7083200 30001068644

Adm Date: 07/16/04

Attending: 05464 BEARY MD, WILLIAM M Resident: 07674 MOVVA MBBS, SUNIL

Svc/Team: MPU MICU

Sex: M Isol: N

Room/Bed: J4A J4A 05 IA

Age: 37 yrs 10 mos 25 days Birth Date: 08/21/1966

08171 WARTHAN MD, MOLLY MAE

207362 Wt: 104. kg Ht:

cm

TRANSPORT:

TDC #: 001172218

ALLERGIES/CONTRAINDICATIONS:

NKA-UNVERIFIED

Diagnosis:

DEP DESCRIPTION

ORDER #

ADM ADMIT TO: SVC= MPU / TRAM= MICU ADMIT DT/TM: 07/16/04 03:22

24

CON CONSULT: EEG/EVOKED POTENTIAL - STAT SEE COMMENTS COMMENTS: 37 Y.O. WM WITH DRUG OD (TCA) POSSIBLE SEPSIS IN POOR CONDITION. EVALUATE FOR POSSIBLE SEIZURES.

START DT/TM: 07/16/04 09:18

----- Ordered By: 08171 WARTHAN MD, MOLLY MAE

207362 @ 07/16/04 09:17 07 -----

Confidential: Medical Record Copy - Place in Patient's Chart

09:18 07/16/04 FROM R946, OESESOFA

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DATE/H	SIGNATURE
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PATIENT ID CARD OR LA	BEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW	
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708320 ROBERTS	N RICKY	
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		Medical Record
410U-	l Copy of OIG case to Litigation Support on 06.26.2013 by scm.	

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FOR DISPENSING BY NON- PROPRIETARY NAME UN- DER UTMB FORMULARY SYSTEM UNLESS OTHER- WISE SPECIFIED. ALLERGIES:	E ORDERS WITH SIGNATURI	E, DATE AND HOUF
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PATIENT ID CARD OR LABEL IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW	٧	
	PHYSICIAN'S OR	DER SHEET
001172218		
001172218 7083200 cms 08-21-66 ROBERTSON , RICKY 30001068644 MPU	Medical Record Form	
30001068644 MPU	The University of Texas Me Galveston,	dicai Branch Hospit Texas
1	Original - Medic	cal Record

07/16/04 ROBERTSON , RICKY

708320Q 30001068644

INCLUSION CRITERIA: ALL ADULT PATIENTS WHO ARE EXPECTED TO BE

BEDRIDDEN GREATER THAN 12 HOURS AND EXHIBIT RISK FACTORS FOR THE DEVELOPMENT OF DEEP

VEIN THROMBOSIS.

EXCLUSION CRITERIA: HEPARIN THERAPY SHOULD NOT BE

ADMINISTERED IN PATIENTS WITH A HISTORY OF BLEEDING DISORDERS(PEPTIC ULCER DISEASE, von WILLEBRAND'S DISEASE, HEMOPHILIA; HEPARIN ALLERGY OR ADVERSE REACTION; INTRACRANIAL DISEASE

PROCESS.

RISK SCORE RISK SCORE

AGE 40-60

AGE 61-70(SCORE 2)

AGE > 70(SCORE 3)

SURGERY TIME OVER 2H

SEVEDE SEPSIS

OBESITY(>20% IDEAL BODY WEIGHT)

PREVIOUS OR FUTURE IMMOBILITY (>72H)

PELVIC OR LONG BONE FRACTURE

SYMPTOMATIC VARICOSE VEINS

H/O DVT OR PULMONARY EMBOLUS(SCORE 3)

SEVERE SEPSIS

H/O DVT OR PULMONARY EMBOLUS(SCORE 3)

MI

PREGNANCY/POST-PARTUM LESS THAN 1 MONTH

MALICIANT D7 (SCORE 3) NO SVIN CA

HI DOSE ESTROGEN USE
MULT TRAUMA(SCORE2)
MALIGNANT DZ,(SCORE 2),NO SKIN CA
VENOUS STASIS DISEASE INCL EDEMA,
ULCER STASIS,SYMP VARICOSE VEINS

INFLAM BOWEL DZ CONGESTIVE HEART FAILURE

PARALYSIS CENTRAL VENOUS ACCESS(SCORE 0)

SPINAL CORD INJURY THROMBOPHILIA (SCORE 3)

TOTAL RISK FACTOR SCORE O
PT INCLUDED IN DVT PROPHYLAXIS PROTOCOL? NO
REASON IF EXCLUDED PT WILL NOT BE BEDRIDDEN >12H

NOTE: THE CLINICAL PRACTICE GUIDELINE/PROTOCOL IS MEANT TO SERVE AS A GUIDELINE FOR ROUTINE PATIENT CARE. WHEN THE CONDITION OF THE PATIENT WARRANTS, TREATMENT DECISIONS MUST BE DICTATED BY THE SKILL AND JUDGEMENT OF THE HEALTH CARE PROFESSIONAL.

Quality Management
The University of Texas Medical Branch Hospitals
Galveston, Texas
DEEP VEIN THROMBOSIS PROPHYLAXIS
PROTOCOL

Original-Medical Record

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lol

	Name	UH#
Time of Initial Assessment:	00:24	Allergies:
HISTORY OF PRESENT ILLNESS:	2-0.01	REVIEW OF SYSTEMS:
	sylve _	— CONSTITUTIONAL: ☐ No Sx ☐ Weakness ☐ Feve
3) you find on	- as	Chills Other
mig lett buren	sym of	EYES: No Sx Pain Vision Chg Other
Jan Brown	Just	ENT: No Sx Sore Throat Nasal Congestion Othe
Musul Sh	Solf lead	ČV: ☐ No Sx ☐ Chest Pain ☐ Palpitations
of m		Other
Hx Limited due to:	Mental State	RESP: No Sx SOS Cough
☐ Condition/Unresponsive		Other
Location:		GI: ☐ No Sx ☐ Abd Pain ☐ Nausea ☐ Vorniting
Quality: Constant Intermitte	ent Burning	
☐ Dull ☐ Sharp ☐ Other	Stabbing	GU: ☐ No Sx ☐ Dysuria ☐ Hematuria ☐ Freq ☐ Incon
Dth D. Moderns		MUSCULOSKELETAL: No Sx.
Severity: Mild Moderate	e 🔲 Severe	Pain inSwelling in
Duration: mins/hrs/da	ys/wks/mos/yrs	Other
Timing: ☐ Onset: ☐ Sudden	☐ Gradual	SKIN: No Rash Offer
Context: Occurred while		NEURO: ☐ No Sx ☐ Headache ☐ Numbness
F . 17		Other
ModifyIng Factors: Relieved/Worsene ☐ Nothing ☐ Rest ☐ Exer		PSYCH: No Sx Depression Anxiety
Position		Other
Other		ENDOCRINE: ☐ No Sx ☐ Weight gain/loss lb
Associated Signs and Symptoms:		Other
☐ Nausea ☐ Vomiting ☐ SOB	☐ None	HEMAT/LYMPH: ☐ No Sx ☐ Swollen Glands
Other		ALLERGIC/IMMUNOL: No Sx \ Hives
		Other
PAST MEDICAL HX: ☐ Non-Contribut ☐ Diabetes		ROS/PFSH obtained by student/other Student signature
Diabetes Current meds	Wright	Reviewed by Faculty Performed by Facult
D' I Mad	of -	PROCEDURES:
Other 154M		☐ Thrombolysis under physician direction/order ☐ Intubation by physician; approach ☐ OT ☐ NT
FAMILY HX: Non-Contributor		Venous access: ☐ periph ☐ central ☐ Laceration repair: Size ☐ cms ☐ simple ☐ interm ☐ compl
☐ Diabetes		Location
Other		Desc Splint
SOCIAL HX: Non-Contributory		[m] A 1/2 [m]
Tobacco ppd	pack yrs	Othër/Re-evaluation
ETOH usage	-	
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Drug Other Dother Dothe	ER CARD	EMERGENCY SERVICES Physician Documentation Form Medical Record Form 7005-11/03 The University of Texas Medical Branch Hospitals Galveston, Texas Original With Red Bar — Medical Record White Copy — Billing

Name	UH #
PHYSICAL EXAMINATION:	FACULTY ATTESTATION (Confirm/Revise):
(+ positive finding; – normal)	RN triage note, medicines, allergies, ROS, PFS History
Positive finding requires a comment	reviewed
	Teviewed
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BP F IIII I V2VIII	
THE PARK	
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Normal except	11-11-
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	n Support on 06.26.2013 by scm.

OBSERVATIONS/SIGNATURE (PLEASE SIGN AND TIME EACH ENTRY):	TIME	PAIN	BP	PULSE	RR	ТЕМР	PULSEOX	INT.
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CONTINUATION PAGE EMERGENCY SERVICES MEDICAL RECORD

Medical Record Form 7005B-Rev. 03/01

The University of Texas Medical Branch Hospitals
Galveston, Texas

Original - Medical Record Yellow - Billing

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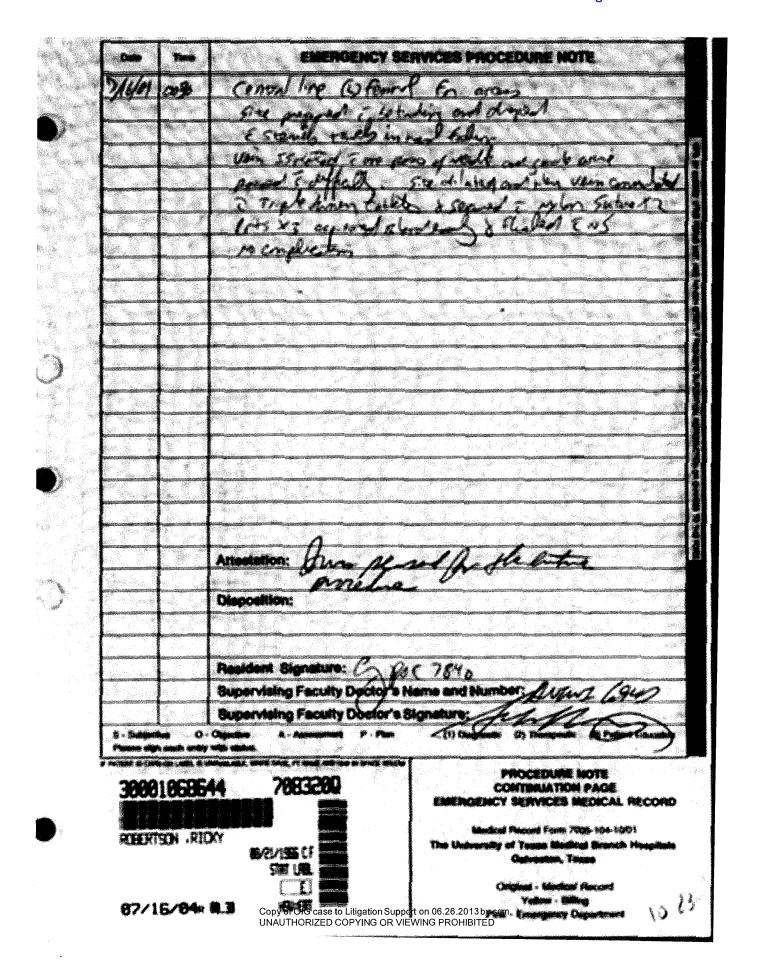
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Medical Record Form 7005B-Rev. 03/01 The University of Texas Medical Branch Hospitals Galveston, Texas

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October 106.26.2013 by sopink - Emergency Department



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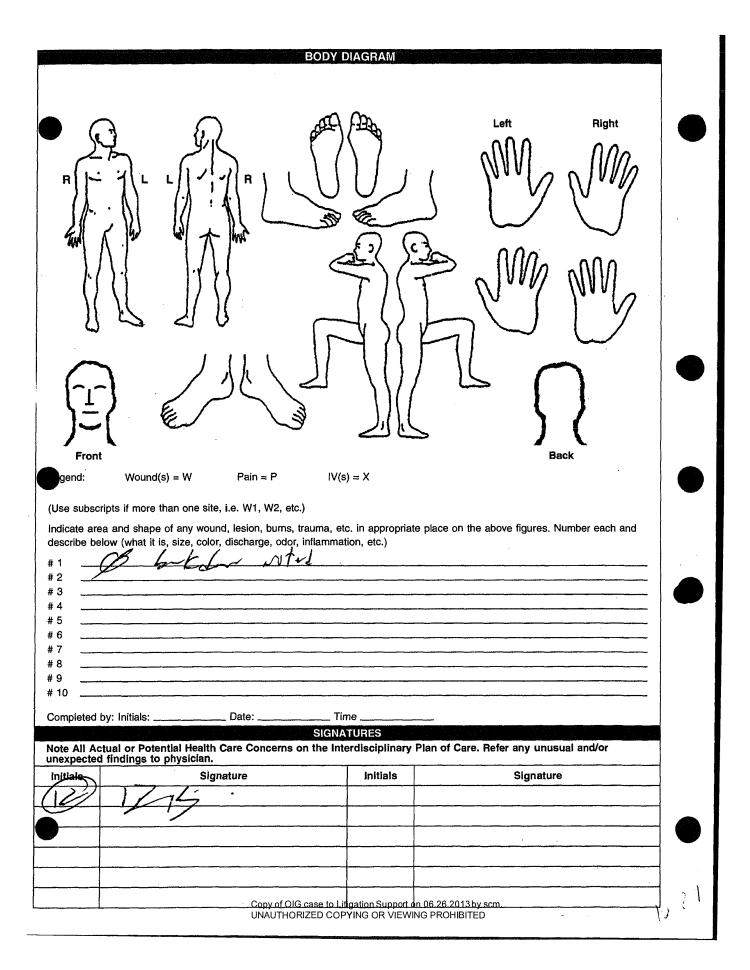
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HISTORY AND PHYSICAL EXAMINATION (Not to be used for Progress Notes)

Medical Record Form 5100-Rev. 11/03 The University of Texas Medical Branch Hospitals Galveston, Texas

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Pt will APACHE IT some 33. Will consider xiguis.	·
Shorten will oblai condia engine & D. Dim	
Short lovenou 100 mg Sa q 12 hrs. will obdor DIC	·
fanel:	
Bydladisaste It all befola desorder &	
defending for the bank : early chipsel	
Respiratory Combine: Likely 2 10 doing overdone vs so fe	<u> </u>
Continue mechanica ventilatio & 15: will add	
loveran after Dic parel & Daine.	
Reflecterero: Rely; to drug oncedore vs cafe: 3	
us meninglis. Calone blind & beels as	
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	ENERAL INFORMATION
Date: 7-16-04 Time: 0420 of Admission	on Allergy bracelet applied: Yes N/A Initials
Admitted from:	Name Band applied by: Initials
☐ Home 🗹 ER	CC/Reason for Hospitalization (state in patients own words):
☐ MD Office/Clinic ☐ Nursing Home	
Other:	MUKNOW , pt willsprain
Primary Informant:	Primary Language:
☐ Patient	☐ Speak ☐ Read ☐ Write
☐ Family Member:	Highest Level of Education:
MOther: Pt. Wrespine	
nisial Vital Cianas	☐ Junior High-grade:
1) P 121 R 12 B/P B3/28	At. Arm High School-grade:
Ht Wt in KG 🖼	College:
HC (Neonatal and Pediatric patients under a	ige 2 only) Occupation:
	1 70
ullergies: ☐ Yes ☐ No ☐ YNKA	Age:
Medications:	Pediatric Patient (Refer to Pediatric age-specific assessment addendu
Reaction:	OB (Refer to OB triage record)
Foods:	To you action that the total action to the state of the s
Reaction:	The Red Size Dia 184 BRUIT
Latex:	1
Reaction:	Relationship: 10001 1000
Other:	Home #: 113 16 7 66 9 3 Work #:
Reaction:	te: 716-cy Time: 0420
	AN NOTIFIED ON ADMISSION
ADVANCE D	IRECTIVES AND GUARDIANSHIP
ADVANCE Didvance Directives (Not required for pediatric patients) noes the patient have:	IRECTIVES AND GUARDIANSHIP Pt. Warespine
ADVANCE Didvance Directives (Not required for pediatric patients) does the patient have: Yes No Directive to Physician (Living Will) If Y	IRECTIVES AND GUARDIANSHIP Pt. Warespine
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ADVANCE Didvance Directives (Not required for pediatric patients) Does the patient have: The Directive to Physician (Living Will) if Yes Directive to Physician (Diving Will) if Yes Directive to Phys	by Date Date Time 0420 IRECTIVES AND GUARDIANSHIP The Washington Date Time 0420 IRECTIVES AND GUARDIANSHIP Yes, document intent: Yes, document intent: Yes No Medical Power of Attorney for Healthcare. If yes, who Name Phone Number Yes No If no, instructed to provide document? Yes No
ADVANCE Didvance Directives (Not required for pediatric patients) loes the patient have: Yes No Directive to Physician (Living Will) If You not not of Hospital DNR yes to any of the above, copy of document provided? loes the patient wish additional information/forms?	Date Date Time Date Time Date Time Date Date Time Date
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dvance Directives (Not required for pediatric patients) oes the patient have: Yes No Directive to Physician (Living Will) If You not provided? Yes No Out of Hospital DNR yes to any of the above, copy of document provided? oes the patient wish additional information/forms? attent/Family given Advance Directive Brochure by equest for additional information/forms referred to usuardianship oes the patient have a Power of Attorney other than Helif so, who oes the patient have a legal guardian? Yes No If so, who	Date Date Time Date Time Date Time Date Date Time Date
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dvance Directives (Not required for pediatric patients) oes the patient have: Directive to Physician (Living Will) If Note that the patient have: Directive to Physician (Living Will) If Note that the patient have a logal guardian? Out of Hospital DNR yes to any of the above, copy of document provided? Out of Hospital DNR yes to any of the above, copy of document provided? Out of Hospital DNR yes to any of the above, copy of document provided? Out of Hospital DNR yes to any of the above, copy of document provided? Out of Hospital Policy explained by Out of Hospital Will information/forms referred to Out of advance Directive Brochure by Out of Hospital Policy explained by Out of Hospital Ville Not assume responsibility for lost or out of the Cashier's Office for satiliables may be deposited in the Cashier's Office for satiliables may b	Date Date Time Date Time Date Date Time Date
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ADVANCE Discretives (Not required for pediatric patients) does the patient have: Yes No Directive to Physician (Living Will) If Yes No Out of Hospital DNR Yes No Out of Hospital DNR Yes to any of the above, copy of document provided? Hoses the patient wish additional information/forms? Hatient/Family given Advance Directive Brochure by Hequest for additional information/forms referred to	Date Date Time Date Time Date Date Time Date
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ADVANCE Discretives (Not required for pediatric patients) advance Directives (Not required for pediatric patients) bees the patient have: Yes No	Date Date Time Date Time Date Date Date Date Time Date
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			PAIN ASS	ESSMENT					
A. Are 1. 2. 3. 4.	Do you have pa Location: Intensity: Scale	periencing pain?	ion?	Pt mi	Sp. c				
5. 6. 7.	Current Treatme Satisfied with tre	eatment? 🗆 Yes 🗀 No	If no, explainB						
8. 9. 10.	What aggravate	ne pain?s the pain?s s the pain have on your f							
	you have any ong Describe:	e associated with the pain going (chronic) painful cor 	ditions? ☐ Yes ☐ No	if yes, complete 1-7.					
3.	3. Is there anything we need to do to continue your current pain management program while you are in the hospital?								
4. What relieves the pain? 5. What aggravates the pain? 6. What factors are associated with the pain? (N/V, dizzy, etc.): 7. Comfort goal: C. Do you expect as a result of this admission that pain may be a problem for you? Yes No Comfort goal set: Comfort goal set: Comfort goal documented in plan of care?									
	ied needs reporte			Date.		Time			
			BRADEN	SCALE	And the second control of the parties of the second	Score			
Sens	ory Perception	1 Completely Limited	2 Very Limited	3 Slightly Limited	4 No Impairment				
Mois		Constantly Moist Bedfast	2 Very Moist 2 Chair fast	3 Occasionally Moist 3 Walks Occasionally	4 Rarely Moist 4 Walks Frequently	3			
Activ Mobi		1 Completely Mobile	2 Very Limited	3 Slightly Impaired	4 No Limitations	 			
Nutri	tion	1 Very Poor	2 Probably Inadequate	3 Adequate	4 Excellent	1			
Fricti	on & Shear	1 Problem	2 Potential Problem	3 No Apparent Problem		1			
A sco	ere of 18 or less re	equires referral to Plan of	Care.	D-71-001	Total Score	B			
Comp	oleted by: Initials: .	(11)	Date:	11109	Time: <i>64</i>	10			
FΔII	PREVENTION A	SSESSMENT: / each ris	FALL PREVENTION Represent for this						
GAG GAG GAG GAG GAG GAG GAG GAG GAG GAG	e over 75 rrently in the ICU itation/confusion/ir paired judgement/ OH abuse/withdra able or unwilling to refer to falls Y of the above by	npaired memory/ delirium/dementia wal o follow directions oxes are √'d, (in behavio	oral medicine, any two b	☐ Dizziness, vertigo ☐ Frequent need to ☐ Orthostasis/hypov Other ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	toilet/incontinence olemia	PREVENTION PLAN			
An An An By Re	esthesla in past 2- ticonvulsants/antic tihypertensives/diu e drops pression scle weakness or stricted by tubing/ steady galt/Uses c O OR MORE of ti	lepressants/tranquilizers/h ıretics/laxatives	ypnotics/sedatives y, etc) ssistance for ambulating (in behavioral medicine	History of seizure: Uncorrected poor Decreased hearin Decreased sensa: Communication in Other History of seizure: Other History of seizure: Uncorrected poor	g tion npairment patient is <u>at risk</u> for falls				
	tient not at risk for	falls Assessed by:Copy of C	·	port on 06.26.2013 by scm	_ RN Date:				

SECTION II To be completed within twelve	e (12) hours of admission to inpati	ent unit or at point of entry as defined by policy.	
	PAST MEDICAL HIST	ORY	
Previous illness, injuries (indicate year):			·
	$-\rho$]	V	
Previous hospitalizations/surgeries (indicate year)	I + VN PSY	2~~	
Indicate with a (1) if the patient or patient's family Pt Family		t Family~ Pt Family ⋅ Pt Fa	mily
Diabetes	☐ ☐ Pacemaker ☐		y □
Stroke Stomach/intestinal	☐ ☐ Fainting/Dizzy Spells ☐		_ _
Rheumatic Disease Urinary Problems	☐ ☐ Liver Disease ☐	**	_
Hepatitis Heart Disease/Atta	ck 🗆 🗎 GYN Problems 🗀]	
HIV/AIDS Positive Chest Pain	☐ ☐ Psychiatric ☐	Cancer 🗆 🗀	
Pertinent Information related to history:	1		
	t. Maryem		
Has the patient had exposure to measles or chick	en now within the last 21 days?	Ves □ No	
Has the patient had a blood transfusion?	•		İ
Has the patient a history of:	Jee, and the patient have	a. 122.12.1. to the traineration.	
· · · · · · · · · · · · · · · · · · ·	be		
Alcohol Use? Yes No If yes, descri	be		
Tobacco use (includes dipping)? ☐ Yes ☐ No	If yes, how many packs per day?		
Current Medications (include over the		ements, diet alds and vitamins)	
Is the patient on any research medications?	es □ No If yes, list below.	•	}
Disposition of medication			
Medication Name	Amount	How often	
Hackman			
Vie IC			
			$\neg \neg$
	FUNCTIONAL INFORMA	TION	
	HEARING SCREEN		
Does the patient have any of the following:	HEARING SCREEN	·	
☐ Yes ☐ No Trouble hearing	☐ Yes ☐ No Patient/family feels	patient may have a hearing loss	- 1
☐ Yes ☐ No Difficulty following spoken instructi		panent may make a meaning tool	
	SPEECH SCREEN	\supset \downarrow \downarrow \downarrow	
Does the patient have any of the following:		Pt. Unrespine	- (
☐ Yes ☐ No Patient can communicate needs		1	1
☐ Yes ☐ No Patient coughs or chokes when ea	· · · · · · · · · · · · · · · · · · ·		1
m of the second	ACTIVITY SCREEN		
Does the patient have difficulty completing any of	-	Vac Dilla Tallalina	
		Yes □ No Tolleting Yes □ No Stair climbing	Ì
	lo Housework	169 LI 10 Otali Cililibiliy	
L. 100 LITO TRAINING L. 100 LIT	SENSORY/COMMUNICATION	SCREEN	
☐ Difficulty with vision, taste, smell, or speech? ☐			
Exceptions:			
Any yes response to above screens requires P	nysician notification.		
Yes No Glasses. If yes, location	•	No. Contacts if was location	
Yes No Hearing aid. If yes, location		•	
• •		•	
Physician notified by:Copy of	Date: 91G case to Litigation Support on 06.	Time: Method:	لبته
UNAUTH	IORIZED COPYING OR VIEWING PI	ROHIBITED \(\frac{1}{3}\).	t *

NUTRITIC	N SCREEN	
Does the patient have any of the following:		
☐ Yes ☐ No Unplanned weight loss (> 10 lbs/month)	☐ Yes ☐ No	inadequate growth/weight
☐ Yes ☐ No Severe food allergies/intolerance/avoidance	☐ Yes ☐ No	Chewing/swallowing difficulties
☐ Yes ☐ No Greater than 3 days of vomiting/diarrhea	☐ Yes ☐ No	Religious dietary considerations
,		risingle de distally some delications
☐ Yes ☐ No Receiving TPN/Tube feedings/supplements		
☐ Yes ☐ No Does not understand or cannot follow special diet		
☐ Multidisciplinary Protocol (includes Nutrition Assessment)	171/11	Date 7-16-04 Time 0420
Any yes response requires a nutrition consult. Consult submitted by		
	TURAL SCREEN	
Religious preference (If patient does not wish to discuss, do not continue)	IN Know)
Would you like to see a clergy? ☐ Yes ☐ No	Nin Kus	~
Will the patient's spiritual/cultural beliefs or practice impact medical treatm	ent? ☐ Yes ☐ No if	yes, describe
Does the patient have cultural or spiritual concerns or items/resources the		alization?
☐ Yes ☐ No If yes, list:		
If yes is checked for any item, consult with Pastoral Care. Consult submitte	d by	Date Time
ABUSE/NEGI	LECT SCREEN	
No signs of abuse or neglect (abnormal bruises, fractures/injuries not cons	sistent with trauma des	cribed, bite marks, burns, malnutrition, dehydration,
pressure sores, chronic poor hygiene, repetitive falls, contractures, fear of	caregivers). No except	tions 🔯 .
Exceptions:		
Any exceptions require a consult with social services. Consult submitted by	y	Date Time
CASE MANAGER/DISCH		
	OJC patient except OB	
Where does the patient plan to go upon discharge?	DOO patient except OD	
If needed, is there someone available to assist the patient when discharge	d? □Yes □No	
If yes, who? (Name and phone number)		
Who will provide transportation to take the patient home? (Name and phor	ne number)	
How much notice will they need? Are there time		
Is the patient currently using medical equipment at home: None We discontinuous the discontinuous transfer of the disconti		
Was the patient receiving home health care services prior to admission?		
If yes, name of agency	_ 163 _ 110	
,		
Social Work and Discharge Planning Considerations		
Check all that apply Transportation difficulties Admitted from long	•	· · · · · ·
☐ Home mobility problems (stairs) ☐ Frail or ADL dependent and living		·
☐ Suspected or confirmed substance abuse ☐ Potential fetal demise	-	· i
□ No permanent housing/place to go after discharge □ Catastrophic illn	iess 🗌 TDJC offende	er that will deliver this admission
☐ Multidisciplinary Protocol (includes Social Work Assessment)		
Any check requires Social Work Consult by whom		Date Time
	HER	
is there anything else that the patient could tell us that would help us mee	t the patients needs?	
Additional comments:		

· CURRENT REVIEW OF HEALTH STATUS
Must be completed by a Registered Nurse within 12 hours of arrival The following parameters will be considered normal. Normal findings will be indicated by checking the No Exceptions box Abnormal finding will be described in the exceptions. Parameters unable to be assessed will be indicated by drawing one line through the parameter.
Cardiovascular: Regular apical pulse. No chest pain. No peripheral edema. Peripheral pulses present in all extremities. Extremities warm and color within patient norm. No calf tenderness. For Infants: No bounding pulses. No murmurs. □ No exceptions □ See ICU Flow Sheet for Exceptions. Exceptions: □ See ICU Flow Sheet for Exceptions.
Respiratory: Respirations regular and unlabored. Nail beds and mucous membranes pink. Breath sounds clear and equal bilaterally Cough absent. No sputum. No exceptions. See ICU Flow Sheet for Exceptions. Exceptions: No exceptions.
Breasts: No patient report of lumps, nipple retraction, discharge or bleeding from nipples, or pain. Last mammogram Exceptions:
Integumentary: Skin warm, dry and intact. Skin color within patient's norm. No petechiae or ecchymosis. ☐ No exceptions. If wound(s) present, indicate location on body diagram. ☐ See ICU Flow Sheet for exceptions. Exceptions: ☐ See ICU Flow Sheet for exceptions.
Gastrointestinal: Abdomen soft, round. No guarding or tenderness. Positive bowel sounds all quads. No nausea, vomiting, diarrheat or constitution. No ostomies. Continent of stool. No exceptions. See ICU Flow Sheet for exceptions. Exceptions:
Last bowel movement Psychological/Emotional/Behavioral: Cooperative. Behavior appropriate for age and situation. Verbalizes adequate sleep. Denies anxiety. For Infants: not fussy, agitated, or irritable. For Children: easily consoled, positive response to distraction techniques. In No exceptions. Exceptions:
Exceptions.
Neurological: Alert and oriented x 4. Active ROM all extremities with symmetry of strength. Verbalization clear and understandable. Swallow intact. No evidence of seizure activity. For Infants: neonatal reflexes appropriate to age.
□ No exceptions. □/See ICU Flow Sheet for exceptions. Exceptions: □
Exceptions.
Genitourinary: Urine clear, yellow or amber. No c/o dysuria, frequency, urgency or retention. Continent of urine. Bladder not distended. No catheters, drain or ostomies. You exceptions. Females: Reports no unusual vaginal bleeding or dysmenorrhea.
Gravida Para LMP Last Pap Smear
Exceptions:
Males: Reports no genital swelling, masses, or prostate problems. ☑ No exceptions. Exceptions:
Hydration Status: Skin turgor elastic, mucous membranes moist. For Infants: Anterior and posterior fontaneles soft and flat. No exceptions. Exceptions:
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Patient Health Care Concern Compairment of skin integrity		. 1		O Withele	7-16-04	-
					1 116.00	1
	•		,		1	7
Patient Goal/Measurable Outcome		····			Date Identifie	
1. Patient will have no skin breakdown			• • • • • • • • • • • • • • • • • • • •		1-16-04	'
2. Patient will have no further skin breakdown if	pre-existing				· /·	_
3		<u> </u>			I V	1
	1:				1	
the same of the sa	Initiate		Date Revise	d Initials	Date Complete	۱!
Plan of Action 1. Assess skin upon edmission then O/Shift & pn			Date Kerise	111111111	OF DIC.	+
2. Keep skin clean & dry, reposition Q 2 hours	1-16	7	 	 	 	+
2. Keep skill created cry, representing a	1-1-	-1-1-	1	 		+
Perform Braden Scale assessment QOD		- 1 1	1 '		·	1
4. OOB as indicated if ordered		1-1-	1	· ·		t
Monitor I&O and nutntional intake	- 	- - -	 			t
. Avoid Pressure from cables, tubings, etc.	$\neg \uparrow \neg \uparrow \neg$		1		,·	t
. Avoid shearing injury by lifting rather than pulling pt			1			Γ
□ Continued	IV	TV				Γ
			.Date			_
atient Health Care Concern . D A	ctual D Pote	ntial	Respived	Initials	Date Identified	
Iteration in comfort: PAIN					7-16-04	-
. اید			1		V 100 - 1	_
atient Goal/Measurable Outcome		···			Date identified	1
Patient will understand & utilize 1-10 scale metho	od of quantify	ing pain			7-16-04	4
Patient will understand the nature of pain and its	treatment wit	h anainesir		1	/ 4	
	iient will be fr		~		-1/	
Patient will identify a control goal of or patient	incin will be in	l l				
	Date		1	t	ete Complete	•
n of Action	Initiated	Initiala I	Date Revised	initials	or D/C	. Ir
Discuss pain scale with patient. Assess and	17-16-04	(R)	1	1	7	
document with VS. Administer energesics as ordered or per PRN sched	1 10-1	10,1	-			_
Assess & evaluate effectiveness of analgesia with	1 /	 - 				
natient ·	1 1 1					
Discuss pain/analgesia regimen effectiveness with						
-hvsician						
Assess for non-verbal pain expression in	11.1	11	1	1		
nconscious of intubated patients						
Discuss regimen effectiveness with physician dentify and discuss pain relief goals with patient						
	V-					
Continued						<u></u>
Is Signature Title	Initials		Signa	pre.		Ti
	D> 1		VX	/	N	
			,			
IO CARO OR LABEL IS UNAVAILABLE WRITE DATE PT NAME AND UNIO IN SPACE BELOW						
		INTERDI	SCIPLINAR	Y PLAN C	OF CARE	
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ROBLE SOUND LUL MPU	Th	e Universit	ly of Texas h	redical Br	anch Hospitals	5
3000108944 Mbn	l l		Galvestor	-	•	

Patient Health Care Concem		Actual C	Poter	tlal	Resolved	Initials	Date Identif	led Initial
Alteration in nutrition				·			7-160	
Patient Goal/Measurable Outcome			1.			ı	Date Identifi	ed Initials
1. Patient will maintain adequate nu	itniional inta	ke as recor	nmend	iea by D	ielician _.		7-16-0	10
2. Patient will be tree of signs of ma	inuintion; i.e	e. laligu e , a	norexi	a, poor s	kin turg or		 	- 14
3. Patient's labs will reflect adequate	e nutrition; I.	e. Albumin,	i otal	Prot. Ele	ctrolyles W	VL	1-4	V
Plan of Action		D Inii	ate /	Initials	Date Revised	i initials	Data Comple	te initials
1. Assess pt. nutritional status upon	admission)+/	6-00	D)	· . 1			
2 Have Dietary consult within 24 hr	of.admit	.	٠	1.				
3. Begin diet, enteral leedings, or TP.	N within 24	1 .	/	· [1.
hours of admission unless contrain	dicated.		1-1		<u> </u>			<u> </u>
4. If NPO, consider enteral feeds or T	PN		 		·		 : 	1
5. Monitor Daily Weight for stability, m	OSI totinor			+-		:		
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Reassess need for restraints Q shift. &	PRN		7				· .	
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Use sedation and Analgesia as ordered/ind Document pt data on Restraint flowshee	icated et	 	+					
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Patient: Robertson, Ricky 708320Q



The University of Texas Medical Branch Galveston, Texas

7/16/04 10:56 AM

7/10/04	10.30 Al	MICU Bed 5 Inpatient Note ICU day 1 Vent Day 1
		The patient was seen and examined with Dr. Beary MD
		History: 39 y/o WM with PMH of bipolar d/o, borderline personality d/o, and
		polysubstance abuse presented to ER from TCD after being found unresponsive in
		TDC at 2210 (7/15/04), with empy stare and axillary temp of 108 F, HR=100,
		BP=98/60, O2 sats=73%. Intubated secondary to hypoxia. In the ER pt. was
		nonresponsive to pain and with fixed dialated pupils with HR=130, BP=76/18, O2
		Sats=100% on FIO2=60%. Pt. had CT head and was volume resuscitated for
		hypotension. Pt. had TCA levels with no QRS prolongation and was started on HCO3.
		Pt. then developed severe hypotension with MAP 20-30 and was started on dopamine
		and levophed to titrate MAP to 60 and was transferred to the floor for further
		management. Pt. started on emperic cefepime 2 g and vancomycin 1 g after
		obtaining BCx.
		PMH: Bipolar D/o with depression
		SH: TDC inmate, PMH of ETOH and tob. use
		FH: NC
		ROS: unable to obtain
		PE in ER:
		VS: HR=125, BP=118/39 (on pressor), T=37.3, O2 sats =96% on 60% FIO2
		GE: on unresponsive
		neck: supple
		HEENT: pt nasally intubated pupils fixed and dialated
		CV: S1S2 normal, tachycardia, no murmurs
		Pul: decreased BS ant, right side inframammary region
		Abd: soft,NT/ND
-		Ext: no pitting edema
		Skin: little excoriations on R. hand and forearm
		Neuro: no gag refles, no responding to stimuli
		Meds prior to admission: Lithium carbonate 600mg BID, chlorapromazine100mg BID,
		Benzytropine 2 mg BID, amantadine 100mg BID, nortriptyline 75 mg QPM, tyenlonol,
		Dantroline 100 mg x1
- 1		

Intern/Resident Signature MMM

Page 1 of 3

Form updated by J. Henderson on 3-17-04

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Patient: Robertson, Ricky 708320Q



The University of Texas Medical Branch Galveston, Texas

7/16/04 10:56 AM

Overnight:
Current Meds: Protonix 40 mg IV BID, heparin 5000 mg SC Q8h, Levofloxacin 500
mg IV
Examination:
BP: 135/41 P: 126 RR: 36 T _{current} : 39.1 T _{max} : 37.5 °C
Vasopressors: none
In/Out: 648/800 over last 24 hours Balance: 0
Urine: over last 24 hours Urine output= 0.0 cc per hour.
 General:pt. intubated and mildly ABD:soft, NT/ND
responsive EXTR:no pitting edema
HEENT:fixed dialated pupils Neuro:no gag reflex, unable to access
Neck:supple Lines:
Card:S1S2 n.; tachycardia Nutrition:
Chest:
Vent Mode:PRVC FiO ₂ :80 Rate:16 PEEP:5 V _t :500
ABG 7.35/30/173/16 on FiO ₂ 100%
A-a Gradient= 503 P/F Ratio =173
Laboratory:
WBC 17.2 Hgb 12.8 Platelets 78 Diff 87.3/5.4
 Na 137 K 3.2 Cl 111 CO ₂ 20 BUN 24 Cr 2.38 Glu 87 AG 6
Ca 7.6 PO ₄ .8 Mg 1.9=
Other Labs: ammonia-17; lactic acid=5.3; PT= 19.8, PT INR=1.8, PTT=50, T4=6.2
Li level=1.4, acetamino<10, salicylate<10, Benzo <16, barb<2, TCA=660,
 amphetamines positive, fibrinogen=82, FDP=>20, D dimer>4.0
 Compression positive intringent of the first and a union in
 Secretions:

Intern/Resident Signature <u>Welly</u>

Page 2 of 3

Form updated by J. Henderson on 3-17-04

Patient: Robertson, Ricky 708320Q



The University of Texas Medical Branch Galveston, Texas

7/16/04 10:56 AM

		ECG:
		CXR:Patchy opacities in the right mid and lower lung may be pul. edema or
		pneumonia. The heart size is normal. The tip of the endotracheal tube is at the level
		of the clavicular heads.
		CT head without contrast: No intracranial hemorrhage, edema, herniation,
		hydrocephalus or acute infarct is identified. The basal cisterns are open. No skull
		fracture is identified. Scant fluid is present in the maxillary and sphenoid sinuses. A
		right nasal tube is in place. No acute intracranial abnormality.
·		Assessment and Plan:
		1. AMS/hypotension- 39 y/o WM with no significant hx of bipolar d/o found
		unresponsive in TDC unit s/p intubation. Pt. with fever, no neck stiffness, negative
		kernigs. PT. with neg. CT of head, increased WBC, normal anion gap, mild non gap
		metabolic acidosis, increased lactic acid level, coagulopathic and with increased TCA
		levels. Diff DX: include drug overdosage (TCA) vs. meningitis vs. sepsis (secondary to
		CAP) vs. MI vs. PE. PT now with profound hypotension and on dopamine and levophed
		WIII obtain Bl. cx., follow lactate levels. COntinue IV fluids, alkalinization, and
		antibiotics (vancomycin, levofloxacin, ceftriaxone. Pt. with APACHE II score of 33. Will
		consider xigris. Will obtain cardiac enzymes and D-Dimer. Start levenox 100 mg SC
		Q12. Following DIC panel.
		2. Respiratory failure- Likely secondary to drug overdose vs. sepsis. Continue
		mechanical ventilation. WIII add lovenox after DIC panel and D-Dimer.
	.,	3. Hypotension-Likely secondary to drug overdose vs. sepsis vs. meningitis, continue
		IV fluids. PT. given 6L of fluid in ER. Also getting HCO3 in IVF for the elevated TCA
		levels.
		Molly Warthan, MD #08171 W. Beary #5464
		(Ferzus)
		· Derzy

Intern/Resident Signature Mode

Page 3 of 3

Form updated by J. Henderson on 3-17-04

	Time	Notes
7/16/0		1CU - Fellew On Call.
7:30A	m ·	Please see full H&P by Dr Monoca.
		Briefly, 37 y mak on antipychatic treatmen
		E Chlorimomazine, lithin & anta amantadine Buny
		to ED p heir found hyporthenic & unresponder
		was interpreted narally.
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		sepris Cartin CMV, IVF. Abx.
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Ricky Roberton.

PROGRESS NOTES

Medical Record Form 5300-Rev. 6/03 The University of Texas Medical Branch Hospitals Galveston, Texas

Original - Medical Record
Copy of OIG case to Litigation Support on 06.26.2013 by scm.
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Date	Time	Notes
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	·	EBL: Sce.
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		Faragi Satter MD.
7/1/20	カーノルー	1/ + 1) + 10 10 C: == 1 C5 01: 0=+1
1/10/04	0/45	Vent up Note: PRVC, Fioz=65%, Peap=+5- PR=16, VT=500. HNguym CRT
1		FR-16 1V1-300 + AVanua CKI
Alula	930	Autrition
majo		see consult section — Ceul Air ROW
1604	1505	Intern Progress Note
,		I spoke with Ray Robertson (Pts brother) and his
		wife Canantha at 1445 to advise them of the Status
		of pt. They were informed that the pts condition was
		capidly deteriorating and that aboth was inswinant furth
		little chance for Meaningfol recovery). Folicussion offline,
		they called back and authorised DNR states and
	·	approval to withhold supportive care with that approval,
		Roy Robertson (269) 683 - 2393
		His mather was called earlier taken by another physician and she denice all responsibility and authority in At
		Management,
		Khan Dans I MA
		#08164
S - Subjectiv		Objective A - Assessment P - Plan (1) Diagnostic (2) Therapeutic (3) Patient Education with status.

PROGRESS NOTES
Copy of OIG case to Litigation Support of Medical Prediction Form 5300-Rev. 6/03 (reverse)
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Date	Time	Notes
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		Found of pulsolors, no rose ausultated after 305,
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		no response to painful gramali, of gag rotter
		@ Cancal roflex
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UH#: 708320Q

Date: 07/16/04 Pt. Name: ROBERTSON , RICKY

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DSC STS:					Priority:		
Account#				3: 08/	21/1966	Room/Bed:	J4A J4A 05
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Intern:							
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From:		BEARY MD			Pager:		409-772-4203
		KHEDERLA					
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Date: 07/16/04 Pt. Name: ROBERTSON , RICKY UH#: 708320Q Account#: 30001068644 Room/Bed: J4A J4A 05
REQUEST FOR CONSULTATION: FOOD AND NUTRITION
Con't Consult Response: (7/16) (37/(11)) (24) 87 Phosphorus 0.81
Goal : @ mest > 75% est ntr woods.
@ maintain hydration.
3 Electrolyte balance 4 renal from wil
Plan: @ Rec place enteral feeding tabe.
@ Suggest Jevity 1,2@80m1/8 goal
rute (2304krul, 107 gm protein, 42 gm fiber
4 1546 MI H20) when renal from return to normal
3 Suacest 150 ml. fluids 93° when 2+
3 Suggest 150 ml. fluids & 3 when pt or goal rate: Francisco fluids as pt transition
to goal rate.
@ start at 10ml then 10ml & 4-6° astol.
Dwesten for silsx of If intolerance, ence
residuals + keep HDB730°
@ Do not keep NPO> 3-5days.
@ will fly & Zx per wk.
@ If pt & brenal for support Osmolite @85m1/0 & 125m1 Hzobolus
Est nto noods: 2275-7730 kcul (25-30 kcul/40)
55-73 any protein (0.60.8 gm/kg) or 73-91 gm protein
(0.8-1.Dam /ka if renal framul) and 2700 miflimes
(30ml/kg)
WRITTEN BY: DATE:/ TIME: : O
SERVICE:EXT#:PAGER:THE UNIVERSITY OF TEXAS MEDICAL BRANCH HOSPITALS - GALVESTON, TEXAS
REQUEST FOR CONSULTATION - MEDICAL RECORD FORM 5411-11/96 ORIGINAL - MEDICAL RECORD

NPC Coulifier MRS objects on 1-72781

HEMATOPATHOLOGY EXT 22249

Patient Account: 30001068-644

Med. Rec. No.: (0000)708320Q

Patient Name: ROBERTSON, RICKY

Age: 37 YRS Sex: M Race: C

Admitting Dr.: BEARY MD, WILLIAM M

Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A University of Texas Medical Branch

Galveston, Texas 77555-0543 (409) 772-1238

(409) 772-1238 Fax (409) 772-5683

UTMB

Discharge Summary

COLLECTION DATE: 07/16/04 07/16/04 COLLECTION TIME: 0110 0500 PROCEDURE REFER RANGE UNITS WBCx10^3 [4.5-10.5] /CMM 17.2H 20.5H RBCx10^6 [4.25-5.65]+ /CMM 4.33f 4.35 G/DL 12.8Lf HGB [13.5-17.0]+ 13.1L [37.0-50.0]+ 36.8Lf 37.0 HCT [82.0-97.0] MCV FL 85.0 85.1 MCH [27.0-33.0] PG 29.6 30.1 MCHC [31.0-36.2] 용 34.8 35.4 [11.8-14.1] RDW 13.4 12.8 PLTx10^3 /CMM [150-400] 781. 831. 10.8 12.3H MPV [7.8-11.2] FL07/16/04 0110 RBCx10^6 REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323. NORMAL LOW FROM 3.90 TO 4.25. NORMAL HIGH FROM 4.95 TO 5.65. RESULT FLAG NOT CHANGED. FOOTNOTE ADDED ON 07/16/04 AT 0323 BY LAB187 07/16/04 0110 HGB REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323. NORMAL LOW FROM 11.5 TO 13.5. NORMAL HIGH FROM 15.5 TO 17.0. RESULT FLAG FROM TO L. 07/16/04 AT 0323 BY LAB187 FOOTNOTE ADDED ON 07/16/04 0110 HCT REFERENCE RANGE CHANGED DUE TO CHANGE OF SEX AT 16JUL2004 0323. NORMAL LOW FROM 34.0 TO 37.0. NORMAL HIGH FROM 45.0 TO 50.0. RESULT FLAG FROM TO To. FOOTNOTE ADDED ON 07/16/04 AT 0323 BY LAB187 DIFFERENTIAL - MANUAL SEGS [45-78]74 19H BANDS 10 - 81LYMPHS [20-51] 5L META [0-2]1 1H MYELO [< 0.7 NRBC/100WB [< 0] 2H

DIFFERENTIAL - AUTOMATED

GRAN% [45.0-78.0] % 87.3H LYMPH% [20.0-51.0] % 5.4L MONO% [4.0-12.0] % 6.6

Legend:

#CELS CNTD

POLYCHROM

L = Low, H = High, $f \approx Footnote$, + = Admit Record Chng

Medical Record Copy

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Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q
Patient Location: J4A - 05
Printed Date ATOTAL:72218

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100

DIFFERENTIAL MORPHOLOGY

2+

Patient Account: 30001068-644 Med. Rec. No.: (0000)708320Q Patient Name: ROBERTSON, RICKY

Age: 37 YRS Sex: M Race: C Admitting Dr.: BEARY MD, WILLIAM M Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

UTMB

University of Texas Medical Branch

Galveston, Texas 77555-0543

(409) 772-1238 Fax (409) 772-5683

Discharge Summary

HEMATOPATHOLOGY EXT 22249

COLLECTION DATE: 07/16/04 07/16/04 COLLECTION TIME: 0110 0500

PROCEDURE REFER RANGE UNITS

DIFFERENTIAL - AUTOMATED

EOS% [0.0-6.0] BASO% [0.0-2.0]윰 0.2 GRAN#x10^3 [2.1-7.4] /CMM 15.0H LYMP#x10^3 [1.3-4.4] /CMM 0.9L MONO#x10^3 [0.2-0.9] /CMM 1.1H EOS#x10^3 [0.0-0.4] /CMM 0.1 BASO#x10^3 [0.0-0.2] 0.0 /CMM IMM GRAN OBSERVED*

COAGULATION

COLLECTION DATE: 07/16/04 07/16/04 COLLECTION TIME: 0110 0500

PROCEDURE REFER RANGE UNITS

19.8H PROTIME PA [10.5-13.9] SEC 28.7H 2.7 PT INR 1.8 SEC 28 28 APTT MN NM APTT PATNT [22-34] SEC 50H 102C MG/DL **82**Cf FIBRINOGEN [200-400] UG/ML >20* FDP [<5] FDP TYPE PLASMA > 4.0f

D DIMER [< 07/16/04 0500 FIBRINOGEN

CRITICAL VALUES (APTT/FIBRINGEN) CALLED TO EVELYN AT 07/16/04 07:19/LT./READBACK VERIFIED BY LT.

D DIMER (08/23/00 -- Current)

RESULTS ARE REPORTED IN uG FEU/ml. FEU = FIBRINOGEN EQUIVALENT UNITS.

Legend: L = Low, H = High, C = Critical, * = Abnormal, f = Footnote

Medical Record Copy Do Not Remove From Chart Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q Patient Location: J4A - 05

Printed Date APA-172218

07/24/04 - 0002Page:

University of Texas Medical Branch

Galveston, Texas 77555-0543 (409) 772-1238

Fax (409) 772-5683

Discharge Summary

30001068-644 Patient Account: Med. Rec. No.: (0000)708320Q Patient Name: ROBÉRTSON, RICKY Age: 37 YRS Sex: M Admitting Dr.: BEARY MD, WILLIAM M

Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

CHEMISTRY EXT 29227

			COLLECTIO		•	07/16/04	07/16/04
			COLLECTIO	N TIME:	0030	0110	0500
	PROCEDURE	REFER	RANGE	UNITS			
	NA	[135-1	45]	MMOL/L		137	137
	K	[3.5-5	.0]	MMOL/L		3.2L	4.1f
	CL	[98-10	8] [.]	MMOL/L		111 H	112 H
	CO2 TOTAL	[23-31]	MMOL/L		20L	19 L
	AGAP	[2-16]				6	6
	BUN	[7-23]		MG/DL		24H	26 H
	GLUCOSE	[70-11	0]	MG/DL		87	129H
À	CREATININE	[070-	1.70]	MG/DL		2.38H	1.89H
,	BUN/CREAT					10.1	13.8
	IONIZED CA	[4.50-	5.30]	MG/DL			4.66
	PH SERUM	[7.34-	7.45]				7.22L
	CALCIUM	[8.6-1	0.6]	MG/DL		7.6L	7.5L
	PHOSPHORUS	[2.5-5	.0]	MG/DL		0.8Cf	1.4L
	MAGNESIUM	[1.7-2	.4]	MG/DL		1.8	1.7
	TROPONIN I	[0.00-3	1.00]	ng/mL			16.01H
	AMMONIA	[9-33]		UMOL/L		17	
Ì	LACT ACID	[0.3-2	.6]	MMOL/L	5.3Cf		5.2Cf

ENZYMES

COLLECTION DATE: 07/16/04 COLLECTION TIME: 0500

PROCEDURE REFER RANGE UNITS 7748H CK [33-194] U/L [< 5.0] CK-MB ng/mL 63.7H CKMB INDEX [0.0-2.5] 8 0.8

CKMB INTER 07/16/04 0500 INCREASED CK AND MB WITH NORMAL %MB SUGGESTS STRIATED MUSCLE INJURY WHICH CAN MASK MYOCARDIAL MUSCLE INJURY.

Legend:

L = Low, H = High, C = Critical, f = Footnote

K..... 07/16/04 0500 SLIGHT HEMOLYSIS PRESENT

PHOSPHORUS..... 07/16/04 0110 CRITICAL VALUE(S) CALLED TO HEATHER ON 07/16/04 01:50 BY LAB217 AND READBACK. PANIC RESULT CALLED TO EMILY AT 07/16/04 02:42/REPEATED LACT ACID..... 07/16/04 0030

LACT ACID..... 07/16/04 0500

CRITICAL VALUE(S) CALLED TO EVELYN ON 07/16/04 09:01 BY 429 AND READBACK. Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q

Patient Location: J4A - 05 Printed Date APA-72218

07/24/04 - 0002Page:

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Patient Account: 30001068-644 Med. Rec. No.: (0000)708320Q Patient Name: ROBÉRTSON, RICKY Age: 37 YRS Sex: M Race: C

dmitting Dr.: BEARY MD, WILLIAM M Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

URINALYSIS EXT 23196

COLLECTION DATE: 07/16/04 COLLECTION TIME: 0500

PROCEDURE REFER RANGE UNITS

COLOR Amber* APPEARANCE Clear SP GRAVITY [1.003-1.030] 1.010 PH [4.8-8.0]8.0 PROTEIN [NEGATIVE] 100mg/dL* GLU U QUAL [NEGATIVE] NEGATIVE KETONES [NEGATIVE] NEGATIVE BILIRUBIN [NEGATIVE] NEGATIVE BLOOD [NEGATIVE] 250/uL* IJROBITI-IN [0-1mg/dL]1 mg/dL NITRITE [NEGATIVE] NEGATIVE LEUK ESTER [NEGATIVE] NEGATIVE

RBC/HPF WBC/HPF BACTERIA [0-3][0-5][NEGATIVE] /HPF /HPF

21H 0 FEW*

THERAPEUTIC DRUGS EXT 29227

COLLECTION DATE: 07/16/04 07/16/04

COLLECTION TIME:

0030 0110 1.4Cf

PROCEDURE REFER RANGE

INTTS MMOL/L

LITHIUM

LITHIUM (05/09/02 -- Current)

THERAPUTIC RANGE: 0.6-1.2 MMOL/L TOXIC: GREATER THAN 1.2 MMOL/L

LITHIUM TL

HOURS N/A

ACETAMINOP

ug/mL

ACETAMINOP (03/23/04 -- Current)

THERAPEUTIC RANGE: 10-30 ug/mL

TOXIC: GREATER THAN 200 ug/mL @ 4 HOUR POST INGESTION

GREATER THAN 50 ug/mL @ 12 HOUR POST INGESTION

ACETAMIN T

HOURS

N/A*

<10*

SALICYLATE

mg/L

<10*

SALICYLATE (03/23/04 -- Current)

THERAPEUTIC RANGE FOR ANALGESIC AND ANTIPYRETIC USE: 20-100 mg/L

THERAPEUTIC RANGE FOR ANTI INFLAMATORY USE: 100-250 mg/L

TOXIC RANGE: GREATER THAN 300 mg/L

SALICYLATE

HOURS

N/A*

H = High, C = Critical, * = Abnormal, f = Footnote

LITHIUM...... 07/16/04 0030 PANIC RESULT CALLED TO EMILY AT 07/16/04 02:41/REPEATED

Medical Record Copy Do Not Remove From Chart Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q Patient Location: J4A - 05

Printed Date MA. 72218

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Galveston, Texas 77555-0543 (409) 772-1238

Fax (409) 772-5683

Discharge Summary

Race: C

TOXICOLOGY EXT 29227

COLLECTION DATE: 07/16/04 COLLECTION TIME: 0110

PROCEDURE REFER RANGE UNITS

30001068-644

Med. Rec. No.: (0000)708320Q

Age: 37 YRS Sex: M

Patient Name: ROBÉRTSON, RICKY

Admitting Dr.: BEARY MD, WILLIAM M

Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

BENZO S BARB S TRICYCLIC

Patient Account:

NG/ML <16f UG/ML

NG/ML 660f

<2f

TOXICOLOGY DRUG SCREEN

DATE/TIME PROCEDURE RESIDATS

THRESHOLD

07/16/04 0110

PRESUMPTIVE POSITIVE

SCREEN CUTOFF:

1000 NG/ML 300 NG/ML

AMP METH COC MET OPIATES

THC

NEGATIVE NEGATIVE NEGATIVE

SCREEN CUTOFF: SCREEN CUTOFF: SCREEN CUTOFF:

300 NG/ML 50 NG/ML

SPECIAL CHEMISTRY EXT 29227

COLLECTION DATE: 07/16/04 COLLECTION TIME:

0110

PROCEDURE REFER RANGE

UNITS

[4.7-11.4]

MCG/DL

T4 TOTAL T4 TOTAL (Initial -- Current)

NORMAL RANGE OR EXPECTED VALUES WILL VARY FOR PATIENTS WHO ARE ON OVULATION CONTROL DRUGS OR PREGNANT.

Legend:

f = Footnote

BENZO S (Initial -- Current)

SERUM RESULTS OBTAINED USING IMMUNOASSAY DO NOT RULE OUT USE OF ALL DRUGS IN A DRUG GROUP DUE TO VARYING CROSS-REACTIVITY WITH THE ANTIBODY.

BARB S (Initial -- Current)

Medical Record Copy

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SERUM RESULTS OBTAINED USING IMMUNOASSAY DO NOT RULE OUT USE OF ALL DRUGS IN A DRUG GROUP DUE TO VARYING CROSS-REACTIVITY WITH THE ANTIBODY.

TRICYCLIC (10/16/01 -- Current)

THE FOLLOWING GUIDELINES ARE RECOMMENDED:

A TOTAL CONCENTRATION GREATER THAN OR EQUAL TO 200 NG/ML FOR DOXEPIN AND METABOLITE OR GREATER THAN OR EQUAL TO 400 NG/ML FOR AMITRIPTYLINE, IMIPRAMINE AND METABOLITES MAY INDICATE TOXICITY AND REQUIRE QUANTITATION BY HPLC.

OTHER DRUGS/COMPOUNDS MAY CROSS-REACT WITH THE TCA ANTIBODY.

Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q

Patient Location: J4A - 05

Printed Date ANA 172218

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07/24/04 - 000Page:

NPtcCiatilffshMF8db4eptsor4-72816

Patient Account: 30001068-644 Med. Rec. No.: (0000)708320Q Patient Name: ROBÉRTSON, RICKY

Age: 37 YRS Sex: M Race: C Admitting Dr.: BEARY MD, WILLIAM M Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

UTMB

University of Texas Medical Branch

Galveston, Texas 77555-0543 (409) 772-1238

Fax (409) 772-5683

Discharge Summary

MICROBIOLOGY - BLOOD CULTURES

EXTENSION: 21738

BLOOD CULTURE ACCESSION # BC-04-13134

COLLECT DATE: 07/16/04 0030 SOURCE: VENOUS BLOOD RECEIVE DATE: 07/16/04 0938

START DATE: 07/16/04 0938

FINAL REPORT:

07/23/04 2000 NO ORGANISMS ISOLATED

_____ BLOOD CULTURE ACCESSION # BC-04-13135 COLLECT DATE: 07/16/04 0030

SOURCE: VENOUS BLOOD RECEIVE DATE: 07/16/04 0938 START DATE: 07/16/04 0938

FINAL REPORT:

07/23/04 2000 NO ORGANISMS ISOLATED

ACCESSION # BC-04-13138 COLLECT DATE: 07/16/04 0530 BLOOD CULTURE

SOURCE: VENOUS BLOOD RECEIVE DATE: 07/16/04 0946

LT HAND PIV START DATE: 07/16/04 0946

FINAL REPORT:

07/23/04 2000 NO ORGANISMS ISOLATED

BLOOD CULTURE ACCESSION # BC-04-13139 COLLECT DATE: 07/16/04 0530 SOURCE: VENOUS BLOOD

RECEIVE DATE: 07/16/04 0946 LT ARM START DATE: 07/16/04 0946

FINAL REPORT:

07/23/04 2000

NO ORGANISMS ISOLATED

MICROBIOLOGY - URINE CULTURES

EXTENSION: 21738

URINE CULTURE ACCESSION # 04-198-1978 COLLECT DATE: 07/16/04 0630

SOURCE: URINE, CATHERIZED RECEIVE DATE: 07/16/04 1129

START DATE: 07/16/04 1129

FINAL REPORT:

Medical Record Copy

Do Not Remove From Chart

07/17/04 0713

NO AEROBIC ORGANISMS ISOLATED

Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q

Patient Location: J4A - 05 Printed Date Mond:72218

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Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q Patient Name: ROBÉRTSON, RICKY Race: C

Age: 37 YRS Sex: M Admitting Dr.: BEARY MD, WILLIAM M
Ordering Dr.: BEARY MD, WILLIAM M Location: JOHN SEALY TOWER 4A

BLOOD GASES

EXTENSION: 21886

			TION DATE:	07/16/04 0031	07/16/04 0520	07/16/04 0916	07/16/04 0947				
	PROCEDURE	REFER RANGE	UNITS								
	PH ART	[7.35-7.45]	0.1.2.2.0	7,35	7. 19 C	7.28L	7.25L				
	PCO2 ART	[35-45]	MM/HG	30L	49H		32L				
		[80-100]	MM/HG	173H	57L	· ·	86				
	HCO3 ART	[22-26]	MEO/L	16 Cf			13C				
_	HCO3 AKI	07	/16/04 0031				r ON 07/16/04	00:48	BY LAB2117	AND	READBACK.
	•	07/16/04 091		CICLLICIE	********		• • • • • • • • • • • • • • • • • • • •				
-		07/16/04 094									
	THB ART	[13.5-18.0]	G/DL		14.8		16.1				
		[94.0-99.0]			81.2L		91.7L				
		[0.0-1.5]	=		0.2		0.1				
		[Initial Cu	-		***						
		NGE FOR OOMIN		LESS THA	N 1.5% FO	R NON-SMOKE	RS -				
	I.C.	MGE FOR COMIN	10 150 110.		0% FOR SM						
	%METHB ART	[0 4-1 5]	8		1.1		1.2				
		[15.0-23.0]	96		16.9		20.7				
V		[7.32-7.42]	ū				7.20C				
_		[41-51]	MM/HG				46				
		[25-40]	MM/HG				39				
	HCO3 VEN	[24-28]	MEQ/L				17 C				
		[13.5-18.0]	G/DL				16.4				
		[52.0-63.0]	8				48.8L				
	• • • • • • • • • • • • • • • • • • • •	[0.0-1.5]	86				0.2				
	%METHB VEN	-	8				0.9				
_	VOL%O2 VEN	•	ક				11.2				
	NA	[135-153]	MEQ/L		141						
	K+	[3.5-5.0]	MEQ/L		3.2L						
		[4.50-5.30]	MG/DL		4.70						

88

Legend: L = Low, H = High, C = Critical, f = Footnote

MG%

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GLUCOSE [70-115]

Patient Name: ROBERTSON, RICKY Med. Rec. No.: (0000)708320Q Patient Location: J4A - 05 Printed Date ANA 172218

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Fax (409) 772-5683

Discharge Summary

Patient Account: 30001068-644
Med. Rec. No.: (0000)708320Q
Patient Name: ROBERTSON, RICKY
Age: 37 YRS Sex: M Race: C
Admitting Dr.: BEARY MD, WILLIAM M
Ordering Dr.: BEARY MD, WILLIAM M

Location: JOHN SEALY TOWER 4A

CANCELLATIONS

	PROCEDURE:	REASON:	DATE/TIME:	CAL	NCEL TECH:
	THYROID STIMULATING HORMONE	HEMOLYZED	07/16/04	0110	LAB2117
	PHOSPHORUS SERUM CALLED KAREN AT 07/16/04 01:24 SAMPLES	HEMOLYZED HEMOLYZED. LAB2117	07/16/04	0110	LAB2117
	СКМВ	HEMOLYZED	07/16/04	0110	LAB2117
_	MAGNESIUM SERUM	HEMOLYZED	07/16/04	0110	LAB2117
	KETONE, SERUM	HEMOLYZED	07/16/04	0110	LAB2117
	TROPONIN I	HEMOLYZEÓ	07/16/04	0110	LAB2117
	BASIC METABOLIC PANEL (80048)	HEMOLYZED	07/16/04	0110	LAB2117
	HEPATIC FUNCTION PANEL (80076)	HEMOLYZED	07/16/04	0110	LAB2117

Medical Record Copy

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Patient Name: ROBERTSON, RICKY
Med. Rec. No.: (0000)708320Q
Patient Location: J4A - 05
Printed Date AGALT2218

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FALL PREVENTION ASSESSMENT: √ eac	th risk factor present for this patient
D /Age over 75	
g Currently in the ICU	
D Agitation/confusion/impaired memory/impaire	ed judoement/delirium/dementis
D ETOH abuse/withdrawal	
Unable or unwilling to follow directions	
Prior history of falls	
Dizziness, vertigo	
Frequent need to toilet/incontinence	
Onhostasis/hypovolemia	
Other	
D	•
Muscle weakness or paralysis Restricted by tubing/equipment (IV, NGT, Foley Unsteady gait/Uses cane or walker/Requires as History of seizures/neurological diagnosis Uncorrected poor vision Decreased hearing	
Decreased sensation	
Communication impairment	•
ther	

WO OR MORE of the above bodes are vid (in behavioral to talls. The fALL PREVENTION PLAN OF CARE MUSwently used forms) Patient not at risk for falls RN	I medicine, any three boxes) this patient is at T BE IMPLEMENTED (available on POE and Date: 7-16-04 Time: 0420
ent & Care is unevaluable. Write date to hame and upp in eface deeds	FALL PREVENTION ASSESSMENT
72218 33200 CMS 08-21-66 ERTSON .RICKY	

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Original-Medical Record

Fall prevention (_		ehavioral med icine)
Bed in low position	1	⊡ ∠Bed e	xit alarm activated
Bed wheels locked	1		ails up x / 4
D Call light in reach			
Communication			
Communication bo	atd	D Note t	ead and pen in reach
Consults/Positive Screen		•	,
		Time:	Received by:
Speech Therapy	Date:	Time:	Received by:
Education			
Family and patient a			
E Family and patient a	bout fall pre	cautions in hom	ne
 Activity restrictions 			·.
Hearing			•
C Hearing device in pl	ace, on and	workin g	•
Immediate environment			
C Minimum equipment			idy
Pathway to bathroom	tree of obsi	lacies	
Medical condition			
Medical condition [: Onhostatic blood pres	ssure check		
Medical condition L: Onhostatic blood pres Mobility	ssure check	e q hre	
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode	ssure check	s q hrs E _ Minimul	m number of helpers to get up =
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up		s qhrs E _ Minimul E _ Non-ski	m number of helpers to get up = d shoes or slippers
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up [: Cane, walker, wheelch		s qhrs E _ Minimul E _ Non-ski	
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up [: Cane, walker, wheelch	nair for mob	s qhrs □ Minimul □ Non-ski ility	d shoes or slippers
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up [: Cane, walker, wheelch teom [: Bathroom light on	nair for mob	E qhrs E Minimul E Non-ski ility E Room n	
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up [: Cane, walker, wheelch [: Bathroom light on [: Room door/window bli	nair for mob	E qhrs E Minimul E Non-ski ility E Room n	d shoes or slippers
Medical condition [: Onhostatic blood pres Mobility [: Bedside commode [: Gait belt when up [: Cane, walker, wheelch com [: Bathroom light on [: Room door/window blis pileting	nair for mob	E Minimul E Non-ski ility E Room n	d shoes or slippers
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FALL PREVENTION PLAN OF CARE

Medical Record Form 5310S-Page 2 -04/03.
The University of Texas Medical Branch Hr as Galveston, Texas

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		Evaluator's Name		Date of Assessment	7-16		T
ensory erception	1. Completely limited:	2. Very limited:	3. Slightly limited:	4. No impairment	0		T
bility to respond leaningfully to ressure-related iscomfort	Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation.	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR	Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.			
uscomort	OR limited ability to feel pain over most of body surface	has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of the body.	has some sensory impairment)		
Moisture Degree to which skin is	Constantly moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is	2 Molst Skin is often but not always moist. Linen must be changed at least once a	3. Occasionally moist: Skin is occasionally moist requiring an extra linen change	Rarety moist Skin is usually dry, linen requires changing only at routine intervals.	7		
exposed to moisture	detected every time patient is moved or turned.	shift.	approximately once a day.		171		١.
Activity	Bedfast: Confined to bed.	Chairfast: Ability to walk severely limited or	Walks occasionally: Walks occasionally during day.	Walks frequently Walks outside the room at least twice a			1
Degree of physical activity.		nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	but for very short distances, with or without assistance. Spends majority of each day in bed or chair.	day and inside room at least once every 2 hours during waking hours.			
Mobility Ability to change and control body position	Completely Immobile: Does not make even slight change in body or extremity position without assistance.	Very limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Slightly limited: Makes frequent though slight changes in body or extremity position independently.	4. No Ilmitations: Makes major and frequent changes in position without assistance.)		
Nutrition	Very poor: Never eats a complete meal. Rarely	2. Probably inadequate: Rarely eats a complete meal and	3. Adequate: Eats over half of most meals.	4. Excellent: Eats most of every meal. Never refuses			丁
Usual food Intake pattern	eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR	generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR	Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR	a meal. Usually eats a total of 4 or more servings of meat and dairy products.			
	is NPO and/or maintained on clear liquids or IV for more than 5 days.	receives less than optimum amount of liquid diet or tube feeding.	is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.				
Friction and shear	Problem: Requires moderate to maximum	Potential Problem: Moves feebly or requires minimum	3. No apparent problem: Moves in bed and in chair	····			
	assistance in moving. Completes lifting without skiding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with	assistance. During a move skin probably sildes to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most	independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		1		
	maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	of the time, but occasionally slides down.					
NPO: Nothing by mouth. JN98055/2-Rev. 7/93	. ² IV: Intravenously. ³ TPN: Total parenter		i Nancy Bergstrom. Copyright, 1988. I 42-7/21/94	Reprinted with permission Total score	8		
•			Brade	en Scale for Predicting F	ressure	Sore Ri	sk
	٥		M	ledical Record Form No. 5642	- Rev. 07/2	1/1994	
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